

BP-A360.060\_Medical History Report

## MEDICAL HISTORY REPORT

U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF PRISONS(THIS INFORMATION IS FOR OFFICIAL AND MEDICALLY CONFIDENTIAL USE ONLY  
AND WILL NOT BE RELEASED TO UNAUTHORIZED PERSONS)

1. LAST NAME-FIRST NAME-MIDDLE NAME		2. REGISTER NUMBER
3. PURPOSE OF EXAMINATION	4. DATE OF EXAMINATION	5. EXAMINING FACILITY
6. STATEMENT OF EXAMINEE'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (Follow by description of past history, if complaint arises)		

7. HAVE YOU EVER (Please check each item)			8. DO YOU (Please check each item)		
YES	NO	(Check each item)	YES	NO	(Check each item)
		Live with anyone who had tuberculosis			Wear glasses or contact lenses
		Coughed up blood			Have vision in both eyes
		Bled excessively after injury or tooth extraction			Wear a hearing aid
		Attempted suicide			Stutter or stammer habitually
		Been a sleepwalker			Wear a brace or back support

9. HAVE YOU EVER HAD OR HAVE YOU NOW (Please check at left of each item)											
YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)	YES	NO	DON'T KNOW	(Check each item)
			Scarlet fever				Adverse reaction to drug or medicine				Epilepsy or fits
			Rheumatic fever								Car, train, sea or air sickness
			Swollen or painful joints				Broken bones				Frequent trouble sleeping
							Tumor, growth, cyst, cancer				Depression or excessive worry
			Frequent or severe headache				Rupture/hernia				Loss of memory or amnesia
							Piles or rectal disease				Nervous trouble of any sort
			Dizziness or fainting spells				Frequent or painful urination				Periods of unconsciousness
			Eye trouble				Bed wetting since age 12				Have you ever had homosexual contact?
			Ear, nose, throat trouble				Kidney stone or blood in urine				Been exposed to AIDS
			Hearing loss								Alcohol Use (Excessive)
			Chronic, frequent colds				Sugar, albumin in urine				Drug Use/Addiction
			Severe tooth, gum trouble				VD-Syphilis, gonorrhea, etc.				Marijuana
			Sinusitis								Cocaine
			Hay Fever				Recent gain or loss of weight				Heroin
			Head injury								L.S.D.
			Skin diseases				Arthritis, Rheumatism, or Bursitis				Amphetamines
			Thyroid trouble								Others: (Specify)

			Tuberculosis				Bone, joint or other deformity				
			Asthma								Alcohol or drug
			Shortness of Breath				Lameness				Withdrawal Problems
			Pain, pressure in chest				Loss of finger or toe				
			Chronic cough				Painful or "Trick" shoulder or elbow				
			Palpitation or pounding heart				Recurrent back pain				
			Heart trouble				"Trick" or locked knee				Been treated for a female disorder
			High or low blood pressure				Foot trouble				Had a change in menstrual pattern
							Neuritis				
			Cramps in your legs				Paralysis (include infantile)				ARE YOU PREGNANT
			Frequent indigestion								SUSPECT YOU ARE PREGNANT
			Stomach, liver, or intestinal trouble								
			Gall bladder trouble or gallstones								
			Jaundice or hepatitis								

11. WHAT IS YOUR USUAL OCCUPATION?

12. ARE YOU (check one)

☐ Right handed      ☐ Left handed

CHECK EACH ITEM YES OR NO EVERY ITEM CHECKED YES MUST BE FULLY EXPLAINED IN BLANK SPACE BELOW

YES	NO		YES	NO	
		13. Have you been refused employment or been unable to hold a job or stay in school because of: A. Sensitivity to chemicals, dust, sunlight, etc.			18. Have you ever had any illness or injury noted? (If yes, specify when, where, and give details.)
		B. Inability to perform certain motions.			19. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.)
		C. Inability to assume certain positions.			20. Have you ever been rejected for military service because of physical, mental, or other reason? (If yes, give date, and reason, for rejections.)
		D. Other medical reasons (If yes, give reasons.)			21. Have you ever been discharged from military service because of physical, mental, or other reasons? (If yes, give date, reason, and type of discharge whether honorable, other than honorable, for unfitness or unsuitability.)
		14. Have you, ever been treated for a mental condition? (If yes, specify when, where, and give details).			22. Have you ever received, is there pending, or have you applied for pension, or compensation for existing disability? (If yes, specify what kind, granted by whom, and what amount, when, why.)
		15. Have you ever been denied life insurance? (Reason and give details.)			
		16. Have you had, or have you been advised to have, any operations? (If yes, describe and give age at which occurred.)			
		17. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.)			

EXPLANATION: (#13-22 ABOVE)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics mentioned above to furnish the Government a complete transcript of my medical record.

TYPED OR PRINTED NAME OF EXAMINEE

SIGNATURE

INTAKE SCREENING:

HAVE THERE BEEN ANY PROBLEMS SINCE STOPPING THE USE OF  
DRUGS OR ALCOHOL? \_\_\_\_\_

INMATE RECEIVED FROM: COURT \_\_\_\_ TRANSFER \_\_\_\_ P.V. \_\_\_\_\_

OTHER \_\_\_\_\_

MEDICAL STAFF'S COMMENTS AND OBSERVATIONS: PLEASE  
DIRECT YOUR ANSWERS TO MENTAL STATUS, POTENTIAL  
SUICIDE APPEARANCE, CONDUCT, STATE OR CONSCIOUSNESS,  
RASHES, JAUNDICE, BRUISES AND/OR MARKS, SWEATING, BODY  
DEFORMITIES, ECT. NOTE OBSERVATIONS IN BLOCK 23 BELOW.

DOES PATIENT NEED TO BE SEEN IMMEDIATELY BY THE  
MEDICAL STAFF YES \_\_\_\_ NO \_\_\_\_

WHAT ARRANGEMENTS HAVE BEEN MADE? \_\_\_\_\_

IF DRUGS HAVE BEEN USED, NOTE TYPE, HOW LONG, HOW  
MUCH, HOW OFTEN, HOW USED. WHEN WERE THEY LAST USED:

DUTY STATUS: TEMPORARY WORK \_\_\_\_ RESTRICTED \_\_\_\_\_

GENERAL POPULATION \_\_\_\_ YES \_\_\_\_ NO \_\_\_\_\_

TYPE AND EXTENT OF LIMITATION \_\_\_\_\_

23. Physician's summary and elaboration of all pertinent data (Physician shall comment on all positive answers in item 6 through 22. Physician may develop by interview any additional medical history he deems important, and record any significant findings here.)

TYPED OR PRINTED NAME OF PHYSICIAN OR  
EXAMINER

DATE

SIGNATURE

NUMBER OF ATTACHED SHEETS